

**The Burdett Trust for Nursing Empowerment Programme**

**FINAL PROJECT REPORT OF OUTCOMES AND ACHIEVEMENTS  
31<sup>ST</sup> JULY 2013**

**Study Title:** Improving the sexual health of homeless people: Does providing care within hostels improve contraceptive use and uptake of sexual health screening?

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**Study Sites:** St Mungo's Hostels

**Ethical review:** Southampton B REC. Ref 12/SC/0301

## Background

In England it is estimated that 40,500 individuals are living in hostels because they are homeless or at risk of becoming homeless, in London this is estimated to be 3,000 people<sup>1</sup>. St Mungo's charity provides accommodation for around 1,700 people in a mix of housing projects from emergency hostels to supported housing to semi-independent homes for people with complex needs.

Department of Health policy suggests that homeless people require targeted, specialist services<sup>2</sup>. Mental health problems contribute to the behaviour that leads to homelessness<sup>3</sup> and chaotic lifestyles and drug and alcohol use makes them less able to secure permanent accommodation and without an address it becomes much harder to access health and other services<sup>4</sup>. Homeless people are often very wary of statutory organisations and services may be inflexible and unable to respond to their complex needs<sup>5</sup>.

Factors that lead to homelessness are a risk for poor health in general and communal group living increases the risk of exposure to infectious disease<sup>6</sup>. Sex work is common and known to place women at increased risk of sexually transmitted Infections (STI's), blood borne viruses (BBV)<sup>6,7</sup> and unintended pregnancy<sup>8</sup>. Little is known about the sexual health of homeless men.

The project aimed to improve the sexual health of homeless women & men at St Mungo's hostels. A multidisciplinary team has worked with the aim of empowering those within these groups to improve their sexual and reproductive health, in order that they can live independently, safely and to help them engage with services to improve mental and physical health, and their social and economic wellbeing.

## Research Question

Does providing sexual health care within hostels improve contraceptive use and uptake of sexual health screening?

## Methods

A Nurse-led satellite outreach sexual health service (CLASH@St Mungo's) managed by Central North West London NHS Foundation Trust and run by Specialist Reproductive Sexual Health Nurses and Health Care Support Workers was established at three hostels in Camden in order to provide appropriate care within a familiar non-threatening environment. The proposed service had been aimed at women but it soon became clear that there was a need for men to attend and the project protocol was reviewed and ethical amendment agreed. Standard operating procedures, service led agreements and clinic protocols were developed and the first clinic opened in late May 2012 in a mixed 55 bed hostel and a second in June 2012 in a 27 bed mainly female hostel. Fully equipped clinical rooms were established and the service included STI screening and treatment, contraceptive provision (including implants and injections), cervical cytology, HIV and other Blood Borne Virus testing and vaccination where applicable. The final clinic opened in a mixed 50 bed hostel in July 2012 but due to room availability, a more limited clinical service was offered with asymptomatic STI screening and non-intervention 'office' contraceptive care. Clinics ran from 12.30 – 3pm once a week in each hostel and in addition the nurses worked with Central London Action for Sexual Health (health promotion service) and with St Mungo's to increase awareness of sexual health issues amongst both staff and residents. Women & men were signposted for other health care as appropriate.

The project was evaluated by (1) analysis of service and epidemiological data (Sexual and Reproductive Health Activity Dataset (SHRAD) and Sexual Health and HIV Activity Property Type Coding (SHRAPT)), extracted from CNWL NHS Foundation Trust electronic record system for the period 1<sup>st</sup> June 2012 to 31<sup>st</sup> May 2013. Data was checked and agreed by the Trust Data performance and Information management team. (2) Client questionnaires (total n= 70, clinic users n=42 and potential users in hostels without a service n=28) were analysed using IBM SPSS v20. The primary outcome was the number of women starting contraception and the number of women & men screened and treated for sexually transmitted infection. (3) Interviews with clients (n=12) and staff (n=6), from the three hostels with a sexual health service and from three similar hostels without the service residents (n=2), staff (n = 2), explored knowledge, attitudes towards sexual health and

contraceptive behaviour of women & men who are homeless. Interviews were transcribed verbatim and analysed using computer assisted NVivo 10 software.

## **Findings**

### Description of service users

161 clients (87 women, 71 men and 3 unknown) used the service with a total of 367 attendances. 151 clients were registered as having clinical interventions and 10 for advice only.

Clients ranged in age from 19 to 76 years with the average age being 37 years for women and 39 years for men. Ethnicity was not well reported (missing data 42 %), of those responding nearly 40% were white British with black Africans being the next largest group at 18%. 94% (n=131) of clients stated they were of heterosexual orientation, 4% (n=6) homosexual, 1% (n=2) bisexual. Sexual health risk factors were not well recorded but 8 clients stated sex working and 4 were men having sex with men. Clients had been homeless for between 2 months and 10 years with a majority over 3 years.

Questionnaire data showed many clients (73% n=51) reported poor general health including chronic long term conditions including asthma, COPD, diabetes, epilepsy and cardiac disease, (33%) reported mental health conditions including depression, anxiety, eating disorders and schizophrenia, (35%) addiction including alcoholism and substance misuse, (10%) and STI's and Blood borne viruses (18%).

Clients reported high cigarette, alcohol and drug use. 89 % smoked cigarettes. 31% estimated that they drank more than 60 units of alcohol per week and over 40% reported street drug use.

### Sexual health clinic attendance

Clients completing the questionnaires (n=40, 2 missing data) were asked when they had last attended a sexual health clinic. 7% (n=3) had never attended a clinic before. 40% (n=16) had not attended in the past year and 28% (n=11) had not attended in the past six months.

STI screening was the main reason for attending the hostel clinic (73% n=31). 14% (n=6) had attended for both an STI screen and for contraception and only 5% (n=2) stated that they had attended for contraception alone. 7% (n=3) attended for specific reasons such as cervical cytology.

### Screening, Diagnosis and Treatment (NHS Trust SHHAPT data)

96 clients had full STI screens to test for Syphilis, Gonorrhoea, Chlamydia, Trichomonas and HIV. 12 full STI screens without HIV tests. 14 HIV only tests and 31 Chlamydia and Gonorrhoea self-taken swab tests. 167 tests for Hepatitis were also carried out. Table 1 shows the infections that were diagnosed and treated.

Table 1

<b>Infections Diagnosed</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
Anogenital warts first infection	1	0	1
Candidiasis	13	0	13
Chlamydia	8	2	10
Gonorrhoea	3	1	4
Syphilis	2	1	3
Trichomonas	2	0	2
Bacterial Vaginosis/ Non Specific Urethritis	6	1	7
Other Infections e.g. Herpes, Pediculosis pubis, Molluscum contagiosum.	19	0	19
<b>Total</b>			<b>59</b>

### Hepatitis

Hepatitis testing was carried out on 96 clients; some clients were tested for more than one hepatitis virus and received follow up testing. In total the number of hepatitis tests performed was 167 (183.5%). The Hepatitis testing between males (43.4%) and females (56.6%) differed only slightly.

Analysed by hepatitis virus test, there were 27 (29.7%) tests for hepatitis A, 90 (98.9%) tests for hepatitis B and 50 (54.9%) for hepatitis C. Results data was missing for 5 of the cases SHHAPT coded as tested for hepatitis.

The test results showed that within those tested for hepatitis A, 11 (44%) were Anti-Hepatitis A IgG positive, indicating immunity, either from vaccination or past infection. 9 tests (10.2%) were found to be positive for hepatitis B, 1 with chronic carriage and 8 with immunity from past infection. 9 tests (18.8%) were positive for hepatitis C of which 7 clients had chronic carrier status (HCV RNA positive) and 2 clients results showed evidence of past infection (Anti HCV positive).

Immunity to hepatitis B virus was shown in 25 (30.1%) results, 17 (20.5%) were immune following vaccination and 8 (9.6%) due to past infection. Of the 58, (69.9%) of clients whose results indicated on-going susceptibility to infection, 52 (62.7%) had no evidence of immunity and 6 (7.2%) had an insufficient level of immunity.

### Contraception

Questionnaire data (n=46 women) showed past use of contraception to be variable with condoms (n=19, 41%) or withdrawal methods (n= 8, 17%) being most commonly used. 4 women had previously used LARC methods.

The SHRAD dataset showed that 28 female clients attended the clinic seeking contraception advice and 11 started a regular contraceptive method with 7 of these being Long Acting Reversible Contraception methods. 4 clients had implants inserted, 1 had injectable contraception and 2 were referred and accompanied to the main clinical service for IUD insertion. 4 clients started oral contraception and 4 clients were supplied with emergency oral contraception.

5 clients attended for pregnancy tests, one of which was positive and referred for further discussion and care. 14 clients attending the service had had previous abnormal cervical cytology and 12 clients had cervical cytology performed at the hostel service.

Packs of condoms were routinely offered to every client and anecdotally accepted by a majority although records were unclear as to numbers of men and women supplied with condoms.

### Client Evaluation of service

Clients were asked to evaluate the service they received via the questionnaire and a majority thought that the service was excellent (65% n=24). 30 % (n= 11) very good and 5% (n=2) acceptable, (5 missing data).

This positive view of the service was supported by those clients interviewed and asked 'what is it you like about the service being in the hostel?' Clients felt comfortable attending the clinic and liked the way the clinic staff were welcoming, friendly, caring and professional.

*'The way they greet you'. 'They keep everything confidential' 'It feels more comfortable'.*

They liked that the clinic was easy to access and was a drop in service.

*'It's good because you don't need an appointment'. 'Girls that still work on the streets[...]  
they don't go out to sexually transmitted disease clinics so it's good that now they're doing it  
in the hostels'*

### Client Interviews

The interviews with clients explored their knowledge, attitudes and contraceptive behaviour. Many clients had harrowing stories to tell of past trauma and abuse and sexwork. It was clear that St Mungo's accommodation and services were a positive factor in their current lives and helping them with substance misuse and mental health issues. Key themes emerging from the data in relation to provision of sexual health services included clients not wanting to travel to access services, only accessing services if they had significant illness or symptoms and needing support to attend. Vaccination programmes were viewed as a good way to encourage initial attendance, as they were seen as less stigmatising than attending a 'sexual health' service. Clients suggested incentivising vaccination programmes.

### Staff interviews

Hostel staff all viewed the clinics as being much needed provision which had had a positive impact within the hostels hosting the service. It was hoped that the service could be

extended to other hostels. Staff discussed the 'quality' not 'quantity' of the provision that had met the needs of individual clients. The health promotion work alongside the clinic service was seen as vital in encouraging attendance and promoting behaviour change.

Nurses and health promotion staff providing the service felt that although there had been challenges in setting up the service in respect of differences in organisational culture and organisation of clinical support services, they were confident that the service identified much unmet need and they felt privileged to be making a difference to such a vulnerable group. Many residents had complex health needs and the need for more joined up working with other health professionals was highlighted as an issue for future service development.

## **Conclusions**

The project has succeeded in improving the sexual health of this vulnerable group who would not normally attend main stream services. Unmet need has been identified including treatment of covert infection that presents a direct risk to homeless individuals and an indirect risk the public health of the wider community.

Contraception is not a priority for this vulnerable group and the project has shown that onsite provision encourages use of regular contraception including long acting reversible methods.

Working in partnership with St Mungo's, the project has empowered nurses to use their skills to provide women & men with the right care, in the right place, at the right time. In addition it has provided a valuable opportunity for health promotion with residents and hostel staff.

The service is to continue through commissioning by the NHS Trust to deliver a core clinic service in two hostels and a 'clinic in a box' outreach service rotating to other hostels.

## Recommendations

Recommendations are for future service and 'clinic in a box' provision to be responsive to individual hostel needs. Specific initiatives to be considered include the development of joined up working with other health care provision such as drug and alcohol services, review of vaccination and cervical screening policy and promotion of condom schemes and contraceptive care. Further research is required into using a vaccination programme to draw residents into sexual health care and in encouraging use of regular contraception.

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